MINNESOTA
DIVISION OF WORKERS' COMPENSATION
RECORDS DEPARTMENT

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

Claimant Name: ______________________________
(Applicant)

Claimant SSN: ______________________________
(Applicant Social Security Number)

Claimant Date of Birth: ______________________________

Prospective Employer: ______________________________

The above referenced claimant authorizes TruDiligence, LLC. access to all workers' compensation files. Claimant further acknowledges that above requestor/employer has made a conditional job offer prior to workers compensation records search. This authorization shall remain in effect for ninety days from the date of claimant's signature, unless claimant notifies the Division of Workers' Compensation in writing before such time, that claimant is revoking said authorization. All information requested is to be used only in compliance with the Americans With Disabilities Act.

______________________________ ______________________________
Claimant Date Claimant Signed
(Applicant's Signature)